



## Special Open Enrollment for Former Physicians Medical Center Carraway Group Health Plan Members

Blue Cross and Blue Shield of Alabama is pleased to offer a Special Open Enrollment for former Physicians Medical Center Carraway Group Health Plan members without health insurance coverage. This affordable health plan is available for a limited time. The Special Open Enrollment program is an individual health insurance plan for individuals and families, not a group product, with no health underwriting required.

### **The monthly cost for this plan is:**

**Single Coverage:                 \$192**  
**Family Coverage:                \$423**

The open enrollment period ends on December 31, 2008. Since this is a limited time offer, it is important that you return your completed application and first month's payment by December 31, 2008. The enclosed Important Information for Special Open Enrollment sheet contains information on who is eligible for this plan plus other information on billing, benefits and waiting periods.

**Please pay special attention to this sheet.**

The program covers hospital, physician and prescription drug expenses when the services are provided through our provider networks in Alabama. There are limited benefits available outside Alabama in the case of accidental injury or medical emergency. The enclosed Summary of Benefits outlines the covered services and benefits.

Please find enclosed a Summary of Benefits, an Important Information sheet, a Special Open Enrollment application, a Credit Card or Echeck Authorization form and a return envelope. If you have any questions about the plan, please call our Customer Service Department at 1 800-292-8868. Remember, you must act now because this open enrollment ends on December 31, 2008. We look forward to the opportunity to serve you.

Sincerely,

A handwritten signature in black ink that reads "Tim Sexton".

Tim Sexton  
Senior Vice President and Chief Marketing Officer

Enclosures

**BLUE CROSS AND BLUE SHIELD OF ALABAMA  
SPECIAL OPEN ENROLLMENT APPLICATION  
Former Physicians Medical Center Carraway Group Health Plan Members**

PLEASE PRINT:

APPLICANT'S LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ INITIAL \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ COUNTY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

MARITAL STATUS:  Single  Married Phone Number: (\_\_\_\_) \_\_\_\_\_

**LIST NAME OF EACH ELIGIBLE PERSON TO BE COVERED BY THE CONTRACT**

LAST NAME	FIRST NAME	INITIAL	SEX (circle)		SOCIAL SECURITY NUMBER	BIRTHDATE
			M	F		
APPLICANT			<input type="checkbox"/>	<input type="checkbox"/>		
SPOUSE			<input type="checkbox"/>	<input type="checkbox"/>		
CHILD			<input type="checkbox"/>	<input type="checkbox"/>		
CHILD			<input type="checkbox"/>	<input type="checkbox"/>		
CHILD			<input type="checkbox"/>	<input type="checkbox"/>		
CHILD			<input type="checkbox"/>	<input type="checkbox"/>		

**ELIGIBILITY INFORMATION** – In order to be eligible for this coverage, the applicant (1) must be between 19 and 64 years of age and a resident of the state of Alabama; (2) must have been covered on November 30, 2008 as an eligible employee under the Physicians Medical Center Carraway Group Health Plan administered by Blue Cross and Blue Shield of Alabama; (3) must not be covered by any other group or individual health plan (other than the Physicians Medical Center Carraway Group Health Plan); (4) must not be eligible for Medicare; (5) must not be covered by or receive assistance from Medicaid; and (6) must apply for coverage by December 31, 2008.

Were you covered on November 30, 2008 as an eligible employee under the Physicians Medical Center Carraway plan? Yes \_\_\_ No \_\_\_

Were all of your eligible dependents covered on November 30, 2008 as eligible dependents under the Physicians Medical Center Carraway plan? Yes \_\_\_ No \_\_\_

If no, please list the name(s) of any of your eligible dependents that were NOT covered on November 30, 2008 under the Physicians Medical Center Carraway plan:

Are you or any eligible dependents now eligible for Medicare due to age or disability? Yes \_\_\_ No \_\_\_

If yes, please list the name(s) \_\_\_\_\_

Are you or any eligible dependents presently covered by or receiving assistance from Medicaid? Yes \_\_\_ No \_\_\_

If yes, please list the name(s) \_\_\_\_\_

Are you or any eligible dependents presently covered by any individual or group health plan (other than the Physicians Medical Center Carraway plan)? Yes \_\_\_ No \_\_\_

If yes, please list the name(s) \_\_\_\_\_

Are you between 19 and 64 years of age and an Alabama resident? Yes \_\_\_ No \_\_\_

**PREMIUM PAYMENT** – Premiums will be payable in advance on a monthly basis. For your convenience, you may choose to pay by pre-authorized credit card, eCheck, or monthly billing statement by circling your choice below. Send a check or money order for the first month's premium along with your application to Blue Cross and Blue Shield of Alabama, Attention Customer Accounts Department, P.O. Box 995, Birmingham, Alabama 35298. If you choose the eCheck or credit card option, please complete the appropriate enclosed Authorization Agreement.

**CIRCLE ONE:** eCheck    Billing Statement    Credit Card

Please review the back of this application. You must complete the front of the application and sign and date it on the back in order for it to be considered.

# SPECIAL OPEN ENROLLMENT APPLICATION FORMER PHYSICIANS MEDICAL CENTER CARRAWAY GROUP HEALTH PLAN MEMBERS

I am applying for coverage with this Special Open Enrollment program for which I am eligible. I understand that while my fees for the first term are enclosed, the Contract will not become effective until you accept this application. If you accept this application, you will send me the Certificate for which I am eligible along with an identification card showing the date my coverage begins. The Certificate, any changes to the Certificate, this application, and any supplemental applications make up my entire Contract with you.

I agree to pay you in advance the monthly fees. If I am not accepted, your only obligation is to return the fees paid in advance. The fees may be changed with 30 days notice.

I understand that this is a special open enrollment and that if my contract is cancelled for any reason, I may not reapply. I must apply for coverage for my dependents and myself by December 31, 2008. If I am accepted for coverage, I can only add newly acquired dependents after December 31, 2008 as long as I submit an application to you within 30 days of acquiring the new dependent. I understand that each person listed on my application as a dependent child has to be under the age of 25 and I must provide over one half of their support if enrolled in this program now and so long as coverage under the Contract continues.

I understand that my enrolled dependents and I **must serve a waiting period of 365 consecutive days** after my effective date of coverage before benefits for pre-existing conditions are available to any of us under this program. A "pre-existing condition" for purposes of this program includes any condition, disease, disorder, or ailment (including those present at birth) for which there was any medical or surgical treatment, advice, or diagnosis within **two years prior** to my effective date of coverage. **However, this 365-day period will be reduced by any prior "creditable coverage" if there is no greater than a 63-day break in prior "creditable coverage."** Prior creditable coverage means prior coverage under an individual or group health plan including COBRA, Medicare, Medicaid, U.S. Military, TRICARE, Federal Employee Program, Indian Health Service, Peace Corps Service, State Children's Health Insurance Program (SCHIP), a State risk pool or a plan established or maintained by a State, U.S. Government, foreign country or any political subdivision of a State, U.S. Government or foreign country.

I understand that maternity benefits are available only to me, or my spouse, after we have been continuously covered for 365 days. **However, this 365-day period will be reduced by any prior "creditable coverage" if there is no greater than a 63-day break in prior "creditable coverage."** I further understand that maternity benefits are not available to anyone else in my family. I understand this program will not cover me, or my enrolled dependents, for removal of tonsils and adenoids, for a hysterectomy, for insertion of tubes in the ears, for any joint replacement or for treatment of a birth defect until 365 days after my effective date of coverage. **However, this 365-day period will be reduced by any prior "creditable coverage" if there is no greater than a 63-day break in prior "creditable coverage."**

I direct any physician, hospital, health care provider or any other person or entity that has advised, treated, attended, or rendered services or made a diagnosis for me or my dependents or has information or records regarding such, to release them to Blue Cross and Blue Shield of Alabama without further notifying me.

All information I give in this application is true. I understand you are relying on its truth when you decide if you will accept it and issue a contract to me. Any misrepresentation by me will make the Contract invalid from the beginning of its coverage. Any material misrepresentation will be fraud and will be prosecuted by Blue Cross and Blue Shield of Alabama under all laws, state or federal, civil or criminal, to the fullest extent and penalties provided by such laws.

### **Women's Health and Cancer Rights Act Notice**

The Women's Health and Cancer Rights Act of 1998 requires health plans that provide coverage for mastectomies to also provide coverage for reconstructive surgery and prostheses following mastectomies. A participant or dependent who is receiving benefits in connection with a mastectomy will also receive coverage for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of the mastectomy, including lymphedema.

### **Binding Arbitration**

**THE CONTRACT YOU'RE APPLYING FOR INCLUDES BINDING ARBITRATION. THIS MEANS ANY DISAGREEMENT WILL BE SETTLED BY ARBITRATION - NOT A COURT. THE ARBITRATOR'S DECISION IS FINAL AND BINDING. AN ARBITRATOR IS AN INDEPENDENT, NEUTRAL PARTY WHO MAKES A DECISION AFTER LISTENING TO BOTH PARTIES. THIS DECISION CAN'T BE REVIEWED BY A COURT; THE ARBITRATOR ACTS AS JUDGE AND JURY. BY SIGNING YOU AGREE TO SETTLE ANY DISAGREEMENT BY ARBITRATION INSTEAD OF A COURT TRIAL.**

**AGREEMENT TO ARBITRATE - AFTER READING THIS, I AGREE TO THE ARBITRATION PROVISIONS IN THIS CONTRACT.**

I acknowledge by my signature that I have read and understand the front and back of this application, and agree to **binding arbitration**.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## **IMPORTANT INFORMATION FOR SPECIAL OPEN ENROLLMENT FORMER PHYSICIANS MEDICAL CENTER CARRAWAY GROUP HEALTH PLAN MEMBERS**

- In order to be eligible for coverage, an applicant (1) must be between 19 and 64 years of age; (2) must be a resident of Alabama; (3) must have been covered on November 30, 2008 as an eligible employee under the Physicians Medical Center Carraway Group Health Plan administered by Blue Cross and Blue Shield of Alabama; and (4) must apply for coverage by December 31, 2008. The applicant and any covered dependents must not be covered under any individual or group health plan (other than the Physicians Medical Center Carraway Group Health Plan, must not be eligible for Medicare and must not be covered by or receive assistance from Medicaid. Any covered dependents must also have been covered on November 30, 2008 as an eligible dependent under the Physicians Medical Center Carraway Group Health Plan administered by Blue Cross and Blue Shield of Alabama.
- You must name all eligible dependents to be covered on your application. If you choose not to enroll an eligible dependent at the time of your application, you will not be allowed to later enroll that dependent. However, if you acquire a dependent by marriage after December 31, 2008, you may add the dependent (spouse or child) if you submit an enrollment application to Blue Cross and Blue Shield of Alabama within 30 days of the marriage. A child born to you or placed with you for adoption after your effective date may be added if you apply within 30 days of the birth or adoption. If you have only individual coverage you must apply and pay the additional fees for family coverage at the same time you apply to add the dependent. If you fail to add a new dependent within the time period noted above, you will not be permitted to later enroll the dependent.
- If a husband and wife enroll in this plan under two single contracts, they will not be allowed to later combine the two single contracts into one family contract. For example, if a child is born, one of the spouses can add the child to their single contract and form a family contract but the other spouse cannot be added as a dependent on the new family contract.
- If you or a dependent enroll in this program and then later become eligible for Medicare due to age or disability, the plan will not pay primary, secondary or supplemental benefits under Medicare Parts A, B or D. This is true regardless of whether you or a dependent actually enroll for coverage under Medicare.
- Premiums will be payable in advance on a monthly basis. You may pay by pre-authorized automatic eCheck, pre-authorized credit card, or by monthly billing statement. The contract will be cancelled as of the effective date or paid to date of the contract if payment is not received within 30 days of the due date. Premium rates and benefits are subject to change with 30 days notice.
- If accepted, you and any enrolled family members will be covered on the following applicable date after receipt and acceptance of your application and payment: December 1, 2008, December 15, 2008 or January 1, 2009. We will send you a Certificate of Coverage booklet and an identification card after you are enrolled. Your coverage begins on the effective date shown on the identification card.
- There is a 365-day waiting period for pre-existing conditions, for maternity benefits, for the removal of tonsils and adenoids, for a hysterectomy, for insertion of tubes in the ears, for any joint replacement, and for treatment of a birth defect. All other covered medical services will be covered on and after the effective date of your coverage. However, periods of prior "creditable coverage" will reduce the pre-existing and other waiting periods under this program if there is no greater than a 63-day break in prior "creditable coverage." Prior creditable coverage is coverage under an individual or group health plan including COBRA, Medicare, Medicaid, U.S. Military, TRICARE, Federal Employee Program, Indian Health Service, Peace Corps Service, State Children's Health Insurance Program (SCHIP), a State risk pool or a plan established or maintained by a State, U.S. Government, foreign country or any political subdivision of a State, U.S. Government or foreign country.

- If you recently had group coverage, including COBRA, you may be eligible for coverage under the Alabama Health Insurance Program (AHIP). If you qualify for this state sponsored plan, you would not be subject to any pre-existing or other waiting periods. You can reach AHIP by calling the State Employees' Insurance Board in Montgomery, Alabama at 1 866 833-3375. If you become covered by the Special Open Enrollment plan, you would no longer qualify for AHIP.

## **BLUE CROSS AND BLUE SHIELD OF ALABAMA NETWORK PROVIDERS**

In order to receive benefits in Alabama, you must use a Blue Cross and Blue Shield of Alabama network provider. You may view our lists of network providers on our web site at **www.bcbsal.com** or you may call Customer Service at 1 888-372-3909. In order to use your mental and nervous and substance abuse benefits, you must use an Expanded Psychiatric Services (EPS) provider. There are a limited number of these providers. To find an EPS provider call Customer Service or search the online provider directory on our web site. From **www.bcbsal.com**, click on "Find a Doctor." Under "Search in Alabama only," click on "Find a doctor by location." Once there, enter your address information in Step 1, then scroll down in the box called "Select a Specialty" until you find "Psychiatric Services (Expanded)."



**BlueCross BlueShield  
of Alabama**

An Independent Licensee of the Blue Cross and Blue Shield Association.

10-2008

**Special  
Open Enrollment Plan**

# SPECIAL OPEN ENROLLMENT PLAN

The following summarizes the benefits of the Special Open Enrollment Plan.

Benefits are subject to all terms and conditions described in the certificate for this plan. This is not a contract or certificate.

**Please be aware that most benefits are limited to those services or supplies furnished by physicians, hospitals or other Health care providers or facilities in Alabama with whom Blue Cross and Blue Shield of Alabama has a contract.**

## GENERAL PROVISIONS

<b>Calendar Year Deductible*</b>	The first \$1,000 of covered expenses per person each calendar year \$3,000 family maximum per year
<b>Prescription Drug Deductible</b>	The first \$250 of covered prescriptions per person each calendar year
<b>Calendar Year Out-of-Pocket Maximum **</b>	\$3,000 individual calendar year out-of-pocket maximum including the \$1,000 calendar year deductible
<b>Lifetime Maximum ***</b>	\$1,000,000 lifetime maximum for each covered member
<b>Mental and Nervous Disorders and Substance Abuse</b>	Benefits are only available when using an Expanded Psychiatric Services (EPS) provider; benefit details to follow later in this matrix.

\* Deductibles are applied to claims in the order in which they are processed regardless of the order in which they are received. Deductible is not applicable to all services (see specific categories).

\*\* The Out-of-Pocket Maximum does not include the inpatient hospital daily copay, copays to PMD Physicians, coinsurance to Non-Participating and Non-Preferred providers, prescription drug deductible and copays, or non-covered expenses. After the out-of-pocket maximum is met, services which are applicable to the out-of-pocket maximum will be paid at 100% of the Allowed Amount for the remainder of the year.

\*\*\* The \$1,000,000 Lifetime Maximum for each covered member applies to all covered services.

## INPATIENT HOSPITAL BENEFITS

BENEFIT	PARTICIPATING HOSPITAL*	NON-PARTICIPATING HOSPITAL
<b>Inpatient Hospital Coverage</b>  365 days of care during each hospital confinement	\$200 copay per day for the 1 <sup>st</sup> through the 5 <sup>th</sup> days  100% coverage after daily copay for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries**	Not covered  <b>Exception:</b> <b>Accidental Injury and Medical Emergency covered as follows:</b>  Covered at 80% of the Allowed Amount subject to the \$1,000 calendar year deductible
<b>Preadmission Certification</b>	Required for all hospital admissions except maternity. Emergency admissions require notification within 48 hours of admission. <b>For precertification, call 1 800-248-2342 toll-free.</b>	

\* Participating hospitals are those facilities contracted to do business with Blue Cross and Blue Shield of Alabama.

\*\* If you are discharged and readmitted to a hospital within 90 days, the days of each stay will apply toward your 365 day maximum; Inpatient hospital days are limited to combined maximum of days in Participating and Non-Participating Hospitals.

## OUTPATIENT HOSPITAL BENEFITS\*

(Facility charges only – benefit charges for physician and other medical expenses may apply as detailed in the following sections.)

BENEFIT	PREFERRED OUTPATIENT FACILITY	NON-PREFERRED OUTPATIENT FACILITY
<b>Surgery, Diagnostic Lab and X-Ray</b>	Covered at 100% of the Allowed Amount, subject to \$200 facility copay	Not Covered
<b>Dialysis, IV Therapy Chemotherapy and Radiation Therapy</b>	Covered at 100% of the Allowed Amount, No copay required	Not Covered
<b>Accidental Injury and Medical Emergency</b>	Covered at 100% of the Allowed Amount, subject to \$200 facility copay	Covered at 80% of the Allowed Amount subject to the \$1,000 calendar year deductible

\* Benefits will be determined under "Major Medical Benefits" in the Summary of Health Benefits and Health Benefits sections of this booklet for (1) services in the emergency room if the patient's condition does not meet the definition of a Medical Emergency, and (2) outpatient hospital services not listed in this table. Outpatient benefits in Non-Participating Hospitals are available only in cases of Accidental Injury and Medical Emergency.

## PHYSICIAN BENEFITS

Includes the following when licensed and acting within the scope of that license at the time and place you are treated or receive services: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S), Doctor of Medical Dentistry (D.M.D.), Doctor of Chiropractic (D.C.), Doctor of Podiatry (D.P.M.), Doctor of Optometry (O.D.), and Psychologist (Ph.D., Psy.D. or Ed.d), Certified Registered Nurse Practitioners (CRNP); Certified Nurse Midwives (CNM), licensed physician assistant (P.A.) or surgeon assistant (S.A) acting under the direct supervision of a an M.D. who is a preferred provider.

BENEFIT	PMD PHYSICIAN**	NON-PMD PHYSICIAN***
<b>Office Visits and Outpatient Consultations</b>	Subject to \$1,000 calendar year deductible  Covered at 80% of the Allowed Amount after \$30 office visit copay*	Subject to \$1,000 calendar year deductible  <b>In Alabama:</b> Covered at 50% of the Allowed Amount <b>Outside Alabama:</b> Not Covered

BENEFIT	PMD PHYSICIAN**	NON-PMD PHYSICIAN***
<b>Emergency Room Physician Care</b>	Subject to \$1,000 calendar year deductible  Covered at 80% of the Allowed Amount, after the \$60 ER visit copay*	Subject to \$1,000 calendar year deductible  <b>In Alabama:</b> Covered at 50% of the Allowed Amount <b>Outside Alabama:</b> Covered at 80% of the Allowed Amount
<b>Surgery and Assistant Surgery</b>  <b>Anesthesia</b>  <b>Laboratory and Pathology</b>  <b>X-Rays</b>  <b>Chemotherapy and Radiation Therapy</b>  <b>Second Surgical Opinions</b>  <b>In-Hospital Physician Care</b>  <b>In-Hospital Physician Consultations</b>  <b>Maternity</b>	Subject to \$1,000 calendar year deductible  Covered at 80% of the Allowed Amount	Subject to \$1,000 calendar year deductible  <b>In Alabama:</b> Covered at 50% of the Allowed Amount  <b>Outside Alabama:</b> Not Covered
<b>Inpatient Physician Care for Accidental Injury and Medical Emergency</b>	Subject to \$1,000 calendar year deductible  Covered at 80% of the Allowed Amount	Subject to \$1,000 calendar year deductible  <b>In Alabama:</b> Covered at 50% of the Allowed Amount <b>Outside Alabama:</b> Covered at 80% of the Allowed Amount

\* PMD copays required for each office visit per person; PMD copays do not count toward your calendar year out-of-pocket maximum.

\*\* Your 20% PMD coinsurance counts toward your calendar year out-of-pocket maximum.

\*\*\* The amount you must pay a Non-PMD physician does not count toward your calendar year out-of-pocket maximum. If you use a Non-PMD provider, you may have to file your claim, and you will be responsible for charges in excess of the Allowed Amount, applicable deductible, and coinsurance.

PREVENTIVE BENEFITS		
BENEFIT	PMD PHYSICIAN**	NON-PMD PHYSICIAN
<b>Routine Well Child Office Visits</b> Includes four visits during the first year of a baby's life and one visit each year for ages 1 through 5	Subject to \$1,000 calendar year deductible  Covered at 80% of the Allowed Amount subject to \$30 office visit copay*	Not covered
<b>Routine Immunizations</b> (Age limitations apply to certain immunizations)	Subject to \$1,000 calendar year deductible  Covered at 80% of the Allowed Amount	Not covered
<b>In-Hospital Visit for Routine Newborn Care</b>	Subject to \$1,000 calendar year deductible  Covered at 80% of the Allowed Amount	Not covered
<b>Laboratory Charges for Routine Pap Smear</b>	Subject to \$1,000 calendar year deductible  Covered at 80% of the Allowed Amount, limited to one per year	Not covered
<b>Laboratory Charges for Routine Mammogram</b>	Subject to \$1,000 calendar year deductible  Covered at 80% of the Allowed Amount, limited to one baseline exam for females age 35-39 and one per calendar year for age 40 and over  These limits may not apply if you have a family history of breast cancer	Not covered
<b>Routine Prostate Cancer Screening (Prostate specific antigen test and digital rectal exam)</b> One screening each year for males age 40 and over	Subject to \$1,000 calendar year deductible  Covered at 80% of the Allowed Amount	Not covered

\* PMD copays required for each office visit per person; PMD copays do not count toward your calendar year out-of-pocket maximum.

\*\* Your 20% PMD coinsurance counts toward your calendar year out-of-pocket maximum.

### MAJOR MEDICAL BENEFITS\*

BENEFIT	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
<b>Chiropractor Services</b>  Limited to a maximum payment of \$600 per person each calendar year	Subject to \$1,000 calendar year deductible  Covered at 80% of Allowed Amount	Not covered
<b>Home Health and Hospice Care</b>	Subject to \$1,000 calendar year deductible  Covered at 80% of the Allowed Amount	Not covered
<b>Occupational Therapy Services for the Hand and/or Treatment of Lymphedema; Physical Therapy</b>  Limited to a combined maximum of 15 visits per person each calendar year	Subject to \$1,000 calendar year deductible  Covered at 80% of the Allowed Amount	Subject to \$1,000 calendar year deductible  <b>In Alabama:</b> Covered at 50% of the Allowed Amount  <b>Outside Alabama:</b> Not Covered
<b>Durable Medical Equipment</b>	Subject to \$1,000 calendar year deductible  Covered at 80% of the Allowed Amount	Subject to \$1,000 calendar year deductible  Covered at 80% of the Allowed Amount
<b>Ambulance Services</b>	Subject to \$1,000 calendar year deductible  Covered at 80% of Allowed Amount	
<b>Allergy Testing &amp; Treatment</b>  Limited to a combined maximum of \$200 per person each calendar year	Subject to \$1,000 calendar year deductible  Covered at 80% of Allowed Amount	

\* When using a Preferred or Participating Provider, the provider will bill us and we will pay him or her directly. You will be responsible for applicable deductibles, copays, and coinsurance. If you use a Non-Preferred or Non-Participating provider, you may have to file your claim, and you will be responsible for charges in excess of the Allowed Amount, applicable deductible, and coinsurance.

### Benefits for Mental and Nervous Disorders and Substance Abuse

**Note: Benefits are available only when using an Expanded Psychiatric Services (EPS) Provider.**

There are a limited number of EPS providers. They are listed on [www.bcbsal.com](http://www.bcbsal.com) under "Alabama Physician Finder". You may also call Customer Service for a listing.

BENEFIT	Maximum Benefit Amounts	Deductible	Copay
Facility Inpatient Treatment for Mental and Nervous Disorders and Substance Abuse	100% coverage up to 30 days of inpatient care each calendar year when a member is admitted by an EPS Provider	No deductible	No Copay
Physician Inpatient Treatment for Mental and Nervous Disorders and Substance Abuse	100% coverage up to 30 days of inpatient care each calendar year when a member is treated by an EPS Provider	No deductible	No Copay
Outpatient Treatment for Mental and Nervous Disorders and Substance Abuse	100% coverage, no visit limit when treated by an EPS Provider	No deductible	No Copay

### PRESCRIPTION DRUG BENEFITS

<b>Prescription Drugs</b> Copays apply for each 30 day supply for all drugs  Copays are combined for some diabetic supplies	Subject to a \$250 prescription drug deductible per person each calendar year \$15 copay for generic; \$30 copay for Preferred brand; \$50 copay for Non-Preferred brand No benefits are available for drugs purchased at a Non-Participating Pharmacy or for brand name drugs for which there is a generic equivalent available  <b>Note:</b> To view the most current Preferred Brand Drug List, visit our web site at <a href="http://www.bcbsal.com">www.bcbsal.com</a> .
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### INDIVIDUAL CASE MANAGEMENT

<b>Individual Case Management</b>	Coordinates care in event of catastrophic or lengthy illness or injury
<b>Disease Management</b>	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease
<b>Contraceptive Management</b>	Covers prescription contraceptives, which include: birth control pills, injectables, diaphragms, IUDs and other non-experimental FDA approved contraceptives; subject to applicable deductibles, copays and coinsurance.

**Important Note:** This plan does not pay supplemental benefits to Medicare, you should consider enrolling in Medicare and purchasing a Medicare supplement contract when you become eligible for Medicare (generally upon attaining age 65). Medicare supplements - unlike this plan - are designed to fill in most of the gaps in coverage left by Medicare.

# Would you like an easier way to pay for your health care coverage?

## Would you like to eliminate:

- writing checks?
- postage and check costs?
- worry about forgetting to pay for your health care coverage?



**BlueCross BlueShield  
of Alabama**

An Independent Licensee of the Blue Cross and Blue Shield Association.

If so, you should consider using one of Blue Cross and Blue Shield of Alabama's AUTOMATIC PREMIUM PAYMENT methods – designed to offer new and current members an easier way to make fee payments at no additional cost.

### You have 2 options to choose from...

- **E-Check Recurring payment** allows your bank to automatically deduct premiums from your checking account on or after the 1st day of each month and send directly to Blue Cross and Blue Shield of Alabama.
- **Automatic bank card payment** allows your monthly premium to be automatically charged through your credit or debit card and sent directly to Blue Cross and Blue Shield of Alabama on the 1st day of each month.

To start AUTOMATIC PREMIUM PAYMENT, choose the best option for you, and:

1. Complete and sign the appropriate Authorization Agreement (the signature must be an authorized signer for the account).
2. Detach and return the appropriate Authorization Agreement with all other necessary documentation (see information next to coupons for specific requirements) to the address listed next to the coupon.

CAD-56 (Rev. 5-2007)

CMS Approval (5-2007)

**Mail this card to:  
Pay by E-Check**



#### Please Send:

- A blank voided check
- A check for your first or next month's premium
- This fully completed and signed Authorization Agreement

#### Mail To:

Blue Cross and Blue Shield  
of Alabama  
ATTENTION:  
Customer Accounts Department  
450 Riverchase Parkway East  
P.O. Box 995  
Birmingham, AL 35298-0001

### Authorization Agreement for Blue Cross and Blue Shield of Alabama

#### E-Check Recurring Payment

Contract Holder's Name (please print) \_\_\_\_\_ Phone \_\_\_\_\_

Blue Cross and Blue Shield Contract No. (if applicable) \_\_\_\_\_

Bank Name (or financial institution) \_\_\_\_\_

Branch \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Checking Account Number \_\_\_\_\_

I authorize Blue Cross and Blue Shield of Alabama to initiate fee deductions from the checking account and the named bank (or financial institution) specified above to charge such deductions to my account in accordance with the terms and conditions listed on the reverse side of this agreement.

Please check if application is included

Signature \_\_\_\_\_ Date \_\_\_\_\_

(MUST BE AN AUTHORIZED SIGNER ON THE CHECKING ACCOUNT)

**Mail this card to:  
Pay by Bank Card**



#### Please Send:

- This fully completed and signed Authorization Agreement
- Your first month's or next month's premium amount

#### Mail To:

Blue Cross and Blue Shield  
of Alabama  
ATTENTION:  
Customer Accounts Department  
450 Riverchase Parkway East  
P.O. Box 995  
Birmingham, AL 35298-0001

### Authorization Agreement for Blue Cross and Blue Shield of Alabama

#### Automatic Bank Card Payment

Contract Holder's Name (please print) \_\_\_\_\_ Phone \_\_\_\_\_

Blue Cross and Blue Shield Contract No. (if applicable) \_\_\_\_\_

Please check one:  Credit Card – OR –  Debit Card  Visa – OR –  MasterCard

Card Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Name as it appears on the card \_\_\_\_\_

Billing Address for the card/account \_\_\_\_\_  
STREET CITY STATE ZIP

I hereby authorize Blue Cross and Blue Shield of Alabama to charge my credit/debit card for monthly payment of my insurance premium as indicated above. I acknowledge that my premium will be payable in advance on a monthly basis. I acknowledge that the amount of the premium may change.

Please check if application is included

Signature \_\_\_\_\_ Date \_\_\_\_\_

(MUST APPEAR AS IT APPEARS ON YOUR CREDIT/DEBIT CARD)

## **Notice to C Plus Applicants**

If you are applying for C Plus coverage and later become eligible for Medicaid while you are on C Plus, please let us know. As a Medicaid recipient, you are entitled to suspend your C Plus contract if you notify us within 90 days. You do not have to suspend your C Plus contract; however, you may not need a supplemental policy if you have Medicare and Medicaid. Before you take any action on your C Plus contract, contact the Alabama Medicaid office to discuss your options.

## **The Provisions Under This Agreement**

This Authority remains in effect until Blue Cross and Blue Shield of Alabama and BANK (or financial institution) receive written notification from me of its termination in such a time and manner as to give Blue Cross and Blue Shield of Alabama and Bank a reasonable opportunity to act on it (30 days). I have the right to stop payment of a fee deduction by notification to BANK in time to give BANK a reasonable opportunity to act on my request prior to charging my account. After my account has been charged, I have the right to have the amount of an erroneous deduction immediately credited to my account by BANK, provided I send written notice of such erroneous deduction to BANK within 15 days following issuance of the account statement or 45 days after posting, whichever occurs first.

### **IMPORTANT:**

We can only set up automatic deductions on personal checking accounts. You may pay monthly, bi-monthly (two months), or quarterly (three months). Please allow 30 days to process the application and continue to pay your premium until you are notified when the Automatic Premium Payment will begin. The deduction is handled through the Federal Reserve Banking System, and the debit will appear on your monthly statement.

### **IMPORTANT:**

Once we receive your completed Authorization Agreement and a check for one month's premium amount, your payment method will be automatically established. Your monthly premium charge will appear on your credit or debit card statement.